STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445344	A. BUILDING 45: 10/15/16 B. WING 70: 11/09/16	08/31/2016

OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTON HEALTH & REHABILITATION CENTER	3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on review of facility's guidance documentation, medical record review, observation, and interview, the facility failed to complete a urinary incontinence screening and initiate interventions to prevent urinary decline for 2 residents (#188, #87) of 5 residents reviewed for urinary incontinence of 26 residents reviewed. The findings included: Resident #188 was admitted to the facility on 4/29/16, with admitting diagnoses of Right Brain Mass, Hemiplegia,unspecified, Affecting Left Non-Dominant Side, Diabetes Mellitus Type 2, Long Term Use of Anticoagulants, and Major Depressive Disorder. Review of facility guidance, Incontinence Assessment /Toileting Plan, undated,"... Incontinence screens are completed with admission, change in continence status and annually: toileting plans are individualized based on incontinence screening..."	F 315	This Plan of Correction is submitted as required under State and Federal Law. The submission of this plan does not constitute an admission on the part of Holston Health & Rehabilitation Center as to the accuracy of the Surveyors' findings nor the conclusions drawn therefrom. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. Credible allegation of Compliance: F315 1. Resident #87 & #188 have been assessed, the incontinence screening is complete and the care plans have been updated. 2. All residents have been identified as potentially affected for failure to complete a urinary incontinence screening and initiate interventions to prevent urinary decline. To identify any other resident, all current residents' Medical Records will be audited for a completed incontinence screen. 3. Incontinence screens will be completed with the first comprehensive MDS assessment	9/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kes McCord, Adm

TITLE

(X6) DATE: 9/12/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	445344	A. BUILDING _____ B. WING _____	08/31/2016

OMB NO. 0938-0391

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HOLSTON HEALTH & REHABILITATION CENTER	3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914

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F 315	Continued From page 1 Medical record review of the Minimum Data Set (MDS) 5 day assessment dated 7/19/16 and the Quarterly assessment dated 7/25/16, revealed the resident was always incontinent of urine, and had a Brief Interview for Mental Status (BIMS - an evaluation of the resident's cognitive status) of 10, indicating the resident had moderate cognitive impairment. Continued review revealed all prior MDS assessments from admission indicated the resident was always continent of urine, and had a BIMS of 14, indicating the resident was cognitively intact. Medical record review of a facility's Incontinence Screening dated 7/12/16, (the date of the resident's return to the facility following a craniotomy), revealed the screening had not been completed. Medical record review of a facility Incontinence Screening dated 8/31/16 revealed the resident was a possible candidate for bladder training as the resident stated she was willing to use a bedpan but the nurse conducting the interview was unsure the resident understood the concept of bladder training. Observation and interview of the resident on 8/30/16 at 3:00 PM, in the resident's room revealed the resident was unable to communicate. Interview with MDS LPN #1 on 8/30/16 at 3:19 PM, in the MDS office revealed no urinary screening had been completed after the Quarterly MDS dated 7/25/16 documented a decline in urinary status. Continued interview with LPN #1 confirmed a urinary incontinence screening would	F 315	and annual MDS assessments by the MDS nurse. Incontinence screens will be completed by the resident's nurse when a change in incontinence is noted. All Licensed Nurse will be in-serviced by 9/30/16 as to when to complete a urinary incontinence screening and initiate interventions to prevent urinary decline as necessary or desired by resident. 4. The DON, MDS Coordinator or designee will complete a QA study monthly x2 on ALL new admissions or re-admissions that will include a record review to ensure Incontinence screens and appropriate follow up. Results will be reported monthly to the QA committee consisting of the Medical Director or Physician Designee, DON or Designee, Administrator, Dietician, and other team members. After initial 2-month monitoring, QA frequency may be reduced depending on results.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTON HEALTH & REHABILITATION CENTER	3915 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914

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F 315	Continued From page 2 be initiated after a decline on any resident per facility Incontinence Assessment/ Toileting Plan Guidance. Interview with the MDS Coordinator on 8/30/16 at 3:40 PM, in the MDS office, confirmed a urinary screening had not been completed after the resident's decline, per facility Incontinence Assessment/ Toileting Plan Guidance. Resident #87 was admitted to the facility on 2/17/12 with diagnoses including Chronic Kidney Disease, Osteoporosis, Osteoarthritis, Peripheral Vascular Disease, Glaucoma, Epilepsy, Edema, Depressive Disorder, Hypothyroidism, Deep Vein Thrombosis, Gastroesophogeal Reflux Disease, and History of Cerebral Infarction. Medical record review of the Quarterly MDS dated 2/15/16, revealed Resident #87 had a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Continued review revealed the resident was always continent of urine. Medical record review of the Quarterly MDS dated 5/10/16, revealed Resident #87 was occasionally incontinent (less than 7 episodes of incontinence) of urine. Medical record review revealed no documentation an Incontinence Screening had been initiated after a change in the resident's continence status.	F 315		

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F 315	Continued From page 3 Observation and interview with Resident #87 on 8/31/16 at 2:00 PM in the sitting room revealed the resident was continent of urine at all times. Continued interview revealed the resident uses her call light for assistance to use a bedpan during the night because she has edema in her feet and prefers not to get out of bed. Interview with the MDS Coordinator on 8/31/16 at 2:45 PM, in the MDS office, confirmed an Incontinence Screening had not been completed per facility Incontinence/Toileting Plan.	F 315		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation, and interview, the facility failed to ensure liquid nutritional products for resident use were maintained within the manufacturer's expiration dates in 1 of 2 resident nourishment refrigerators observed. The findings included: Review of the facility policy, Safety and Sanitation	F 371	Credible allegation of Compliance: F371 1. No residents were found to have been affected by the out of date tube feeding supply (7 cans of Jevity 1.2) All 7 cans were disposed of immediately on 8/31/16. 2. A review of ALL patients with tube feeding from June 2016 thru August 2016 was conducted. No residents were on this type of nutritional support. 3. RD, CDM and/or their designee will review ALL tube feeding nutritional support supplies on a monthly basis to ensure products available for use are within the "use by" date. 4. This review will be conducted for next 3 months and results reported to the QA committee consisting of the Medical Director or Physician Designee, DON or Designee,	9/30/16

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F 371	Continued From page 4 Best Practice Guidelines: Nourishment Pantries, revised 1/2011, Guidelines: #4 "...Other items such as beverages, crackers, cookies...will be discarded as appropriate..." Observation of the resident nourishment refrigerator on the West hall in the nourishment room, with the Certified Dietary Manager (CDM) on 8/30/16 at 9:19 AM, revealed 7 of 9, 8 ounce cans of Jevity 1.2 calorie (a liquid nutritional source used for tube feeding) had expiration dates of 4/1/16, and was available for resident' use. The CDM confirmed the 7 cans of Jevity 1.2 had expired, and should have been discarded per facility policy.	F 371	Administrator, Dietitian, and other team members. After initial 3-month monitoring, QA frequency may be reduced depending on results. Credible allegation of Compliance: F412 1. Resident #118 is scheduled to be seen by One Care Dental on 9/20/16.	9/30/16
F 412 S8=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide dental services for 1 resident (#118) of 26 residents reviewed.	F 412	2. All residents have been screened as of 9/12/16 to identify those needing dental services in preparation for the 9/20/16 visit. All consents for treatment have been obtained for this visit. Spoke with representative at One Care Dental to establish a procedure to inform the center when a consent for treatment cannot be obtained by One Care, so the center staff can intervene, therefore ensuring referred patients are seen timely. 3. All staff will be re-inserviced by 9/30/16 on the referral process for dental services via the Social Service department. Social Services will maintain an on-going log for patients referred for dental services. MDS nurses will inform Social Services if a patient is coded on the MDS for dental needs, so a referral can be made for services.	

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F 412	Continued From page 5 The findings included: Medical record review revealed Resident #118 was admitted to the facility on 6/19/14 with diagnoses including End Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus, Major Depressive Disorder, Diverticulosis, and Dysphagia. Medical record review of the annual Minimum Data Set assessment dated 5/12/16 revealed the resident scored 14 out of 15 on the Brief Interview for Mental Status, indicating the resident was independent with daily decision making, required extensive assistance of 1 person with bed mobility, transfer, toilet use, and personal hygiene. Medical record review of the social services progress note dated 2/22/16 revealed "...res. [resident] states she wants to see dentist next visit..." Medical record review of the OneCare Dental Solutions schedule for the facility visit dated 3/15/16, and 6/20/16 revealed Resident #118 was not on the list to be seen. Observation of Resident #118 on 8/31/16 at 1:07 PM, in the resident's room, revealed the resident eating her lunch, smiling with no upper teeth, and missing multiple bottom teeth. Interview with the Director of Nursing and Social Worker #1 on 8/31/16 at 1:55 PM, in the social services office, confirmed the facility failed to provide dental services for Resident #118.	F 412	4. Social Services or designee will complete a QA study monthly x 3 that will address obtaining consent for treatment for dental services, and referral to dental services. These finding will be reported in the monthly QA committee meeting consisting of the Medical Director or Physician Designee, DON or designee, Administrator, Social Services, Dietitian, and other team members. After initial 3 month monitoring, QA frequency may be reduced depending on results.	